LOUISIANA TECHNOLOGY INNOVATION FUND PROPOSAL

I   PROJECT TITLE
Pharmacy Compliance Audit Function

II   PROJECT LEADER

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III   EXECUTIVE SUMMARY

The Department of Health and Hospitals, Pharmacy Benefits Management Unit, in partnership with the University of New Orleans, is submitting this request for a project intended to provide an innovative, more cost effective way to perform the federally mandated pharmacy audit/review function and third party liability recovery functions.   The users being served will be the tax payers of Louisiana, Medicaid recipients, pharmacy providers, rebate auditors, and drug manufacturers.   The technology being applied is Microsoft Standard Query Language (SQL) Server 2000 Analysis services and data warehouse. The amount of funds requested is $508,746 with a planned operational date of January 1, 2004.

IV   DESCRIPTION OF THE PROJECT

A. Project Narrative

In order to comply with federal regulations, Medicaid claims must be reviewed. The purpose of the federally mandated pharmacy audit function is to assure that Medicaid providers are billing claims in compliance with state and federal regulations.

While this goal is being met under the current method, we feel it can be met more cost effectively under the proposed method. The agency's idea is to completely change the business process by which the pharmacy audit function is performed. Changes to the program can be categorized into three main areas:

1) Change in type of auditing - The current process is to audit one pharmacy for all types of discrepancies and the new process would be to look at Discrepancy Types across all pharmacy providers.

2) Timeliness – with this new process, claims as recent as one (1) month old can be reviewed. The old process often reviewed claims greater than one (1) year old. Reviewing more recent claims will translate into more collectible dollars and additional pharmacy compliance.

3) Better use of field audit dollars – By tracking the number of Discrepancy Type errors found per pharmacy, we can create a list of top pharmacy providers that should have a field audit. This would prevent us from selecting and spending a large sum of money field auditing a historically compliant provider. This way we would spend the field audit dollars on largely non-compliant providers, thereby getting the most "bang for our buck".

4) Coordination of Third Party Liability (TPL) Recovery – This proposal will assume responsibility of TPL recovery for pharmacy services in the future. Currently the department contracts to pursue TPL Collections for pharmacy services. Assuming

this proposal is approved, the department will no longer need to issue an RFP and contract for these services.

The current method for pharmacy auditing is to issue a Request for Proposal (RFP) in order to select a contractor to primarily field audit a sample of the claims for a sample of pharmacies. This is the most expensive audit method yet it only looks at a sample of the claims, one pharmacy at a time. While this is the normal process for financial auditing, pharmacy claims processing is so unique, that we feel the strategy outlined in this proposal will yield better results. A recent pharmacy audit contract reviewed only 34% of pharmacy claims for a fiscal year (3.8 million out of a total of 11.4 million[1].)

Under our proposed method, by utilizing the new technology described within, 100% of the claims would be reviewed for reasonableness without going into the field as a first resort. The methods that we plan to use have already been successfully implemented on a limited basis by our pharmacy rebate staff, and have also been audited by state legislative performance auditors[2]. We can better target risk areas by reviewing the entire universe of claims.

This concept can best be explained using real life examples because pharmacy claims have unique characteristics to test for compliance. Pharmacy claims are billed using the national standard developed by the National Council for Prescription Drug Programs, NCPDP. The purpose of the Council is to promote standardization that delivers increased efficiency to the pharmacy services sector of the healthcare industry by application of appropriate knowledge transfer technologies within the diverse group of health care providers, payers, and related information processors. This standardization of data elements is used to process and reimburse through pharmacy point of sale on-line systems. Examples of information include eligibility, co-payments, claims processing edits, drug utilization review, coordination of benefits for claims with Third Party Liability, and claim reversals. The same types of errors tend to occur across many pharmacies through common types of billing errors. Following is a sample type of error. After describing this error, we will discuss how the current process would deal with this type of error, and then discuss how the new process would deal with it.

Example #1-Unit Type Discrepancies

Manufacturer A sells a particular drug in three strengths by the vial. The vial is packaged either in 4ml, 6ml or 10ml sizes. Each size holds a different strength of the drug which translates into a different reimbursed price for each vial size. Medicaid reimburses the pharmacies by the vial. Since the reimbursement price is set by the vial, it is vital that providers bill in the Medicaid unit type. In this example, a pharmacy should bill a quantity of one (1) to Medicaid under the particular drug code that corresponds with the 4, 6 or 10 ml, strength. In reality, many pharmacies bill incorrectly by the milliliter, rather than correctly by the vial. This means they bill a quantity of 4 or 6 or 10 instead of the 1. This almost always results in an overpayment to the provider.

> Current Method
> The current method of field auditing would only find these errors if their sample chose one of these claims. Then, the audit would only recover the overpayment on claims for that drug for the audited time period.
>
> Proposed Method
> The proposed method would electronically review 100% of the claims across all pharmacy providers billing for those three drug strengths looking for that particular discrepancy type error. By using the days supply, patient history, and billed charges, we can determine what quantity should have been billed, calculate overpayments and send recovery notifications to ALL providers billing incorrectly, alerting them to the overpayment, and recovering the money. All of this can be done without expensive field travel.

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[1] Medicaid of Louisiana Title XIX Pharmacy Compliance Audits Annual Report Fiscal Year July 1998 – June 1999, Postlethwaite & Netterville, Page 5.

[2] http://www.lla.state.la.us/perform/dhhpp03.pdf, Department of Health and Hospitals, Medical Vendor Program-Pharmacy Program – Incentive Rewards (035001007) (25pgs)

We are currently able to conduct limited analysis for these types of errors using our claims database for the pharmacy rebate program, LAPRIMS. However, we have hundreds of drugs yet to be reviewed. This is because we can only use our rebate claims database to perform these audit functions on a limited basis due to technical and staffing limitations.

To put this in a financial perspective, for example, in FY 1999, the contractor selected under the old RFP method conducted a total of 346 pharmacy audits. From that sample, they identified dollars for recovery for Quantity Type Discrepancies that amounted to **$185, 153**[3].

By comparison, in FY 02, by using the global method, the current rebate staff, while performing the limited audit functions in an effort to resolve drug rebate disputes, identified **1.86 million** dollars[4] in similar quantity type discrepancies found by the contractor in the example above. *The key that allowed the rebate auditors to identify larger dollars for recovery is that all pharmacies were reviewed for this type of error, rather than a sample. **This is the basis for the change to the business process.***

Example #2 – Package Size Discrepancies
Based on rebate disputes, we know that pharmacies commonly bill different inhalers interchangeably. Manufacturer A makes a 17 gram albuterol inhaler, and Manufacturer B makes a 13.4 gram albuterol inhaler. Frequently, providers may bill the drug code for manufacturer B with a quantity of 17. When this occurs, Medicaid will overpay the provider by the cost of 3.6 grams of the drug.

> Current Method
> The current method of field auditing would only find these errors if their sample chose one of these claims. Then, the audit would only recover the overpayment on claims for that drug for the audited time period
> Proposed Method
> The proposed method would electronically isolate all the claims with a drug route common to oral inhalers, and would crosscheck them against the package size. If the package size billed by the provider does not match the package size listed for that National Drug Code (NDC), we would further isolate those claims. We would then electronically calculate the overpayment to the provider and recoup the money. Again, all of this would be done by never leaving a desk. Once the logic is coded, it can be used to isolate those errors for years to come, without relying on expensive manpower or field audits.

The innovation is to completely change the starting point and perspective by which pharmacy claims are reviewed. We can identify common Discrepancy Types, link the errors electronically to pharmacy overpayments and recoup overpaid dollars without ever leaving our desk. We can track errors found while reviewing the entire universe of claims, and further focus the more expensive field audits on the providers exhibiting the most errors found from the universal reviews. It makes sense to review as much as possible from a desk using standard queries that test for compliance before spending the money to go out in the field. Because of technology, we would now be able to expand the population of claims across a number of years, as well as expand the drug entities that are reviewed.

It makes business sense to incorporate Third Party Liability recoveries as a product of this innovation. First a short explanation of TPL is necessary. By law, Medicaid is the "Payor of Last Resort" for medical claims for Medicaid recipients. If a known third party (commercial insurance, Champus, Medicare, etc.) is liable for payment of such claims, payment is automatically denied. This is known as "cost avoidance", which is possible when sufficient information is available in the Medicaid Management Information System (MMIS). However, in some cases, payment is

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[3] Medicaid of Louisiana Title XIX Pharmacy Compliance Audits Annual Report Fiscal Year July 1998 – June 1999, Postlethwaite & Netterville, Page 13.
[4] http://www.lla.state.la.us/perform/dhhpp03.pdf, Department of Health and Hospitals, Medical Vendor Program-Pharmacy Program - Incentive Rewards (03501007) (25 pgs)

made to the providers and then investigated for potential recovery activities. This practice is known as "Pay and Chase".

In development of NCPDP version 5.1 (as described above) the new data elements have created data segments to coordinate benefits. The Point of Sale system will house the entire Medicare and other third party insurer data necessary for recovery of these "pay and chase" dollars. The proposed data warehouse would allow the department to recover these monies without paying an additional party to create and house the same duplicate data. Therefore, the state will not be paying for duplicate efforts for this function.

Other "Pros" of the proposed method include:

1) Money – It is less expensive to use UNO staff since they are not a for profit organization. In addition, utilizing accounting staff as the primary reviewer is less expensive than employing pharmacist time. UNO staff have consistently demonstrated exceptional performance[5] for DHH by identifying the following amounts for recovery during pharmacy claims audit and review:

Fiscal Year	Amount
2001	$ 603,486
2002	$1,869,250
2003	$1,650,339 *(through May 31, 2003)*

2) Scope
    a. ***Larger Volume*** – review a larger universe of claims.
    b. ***Flexibility*** - Increased flexibility speeds up reaction time to changes noted during quarterly global reviews.
    c. ***Adaptability*** - able to easily modify audit parameters based on program and/or policy changes. This is vital in the current dynamic environment.

3) Timely Review –We can look at the most current 6 months time frame (rolling audit period) whereas under the contracted method claims were at a minimum a year old before the first onsite audit. (Paper reports versus electronic review)

4) Technical Staff Onsite – UNO has knowledgeable technical staff with extensive experience with Medicaid pharmacy claims analysis and reporting. They have played a vital roll in the success of the rebate groups' ability to identify and recover overpayments to providers.

5) Ownership – DHH will own the equipment and the knowledge rather than paying someone else to acquire the equipment and knowledge every 3 years.

6) In-house Database - Electronic housing of claim detail that supports the audit findings and will be available in-house via LAPRIMS. This will prevent recoupments for the same discrepancy from both rebate and audit.

7) Decreased Duplication of Efforts - Limited auditing must be undertaken in order to perform pharmacy rebate functions. These efforts would not be duplicated under the proposed method and therefore the state would not be paying twice for these functions.

8) Continuity – Proposed method would eliminate lag time between contracts during which no audits would be performed and decreases the learning curve that would occur every three years under the contract method.

9) Utilize Drug Manufacturer resources in the audit process
    See diagram and narrative below

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[5] http://www.lla.state.la.us/perform/dhhpp03.pdf, Department of Health and Hospitals, Medical Vendor Program-Pharmacy Program - Incentive Rewards (03501007) (25 pgs)
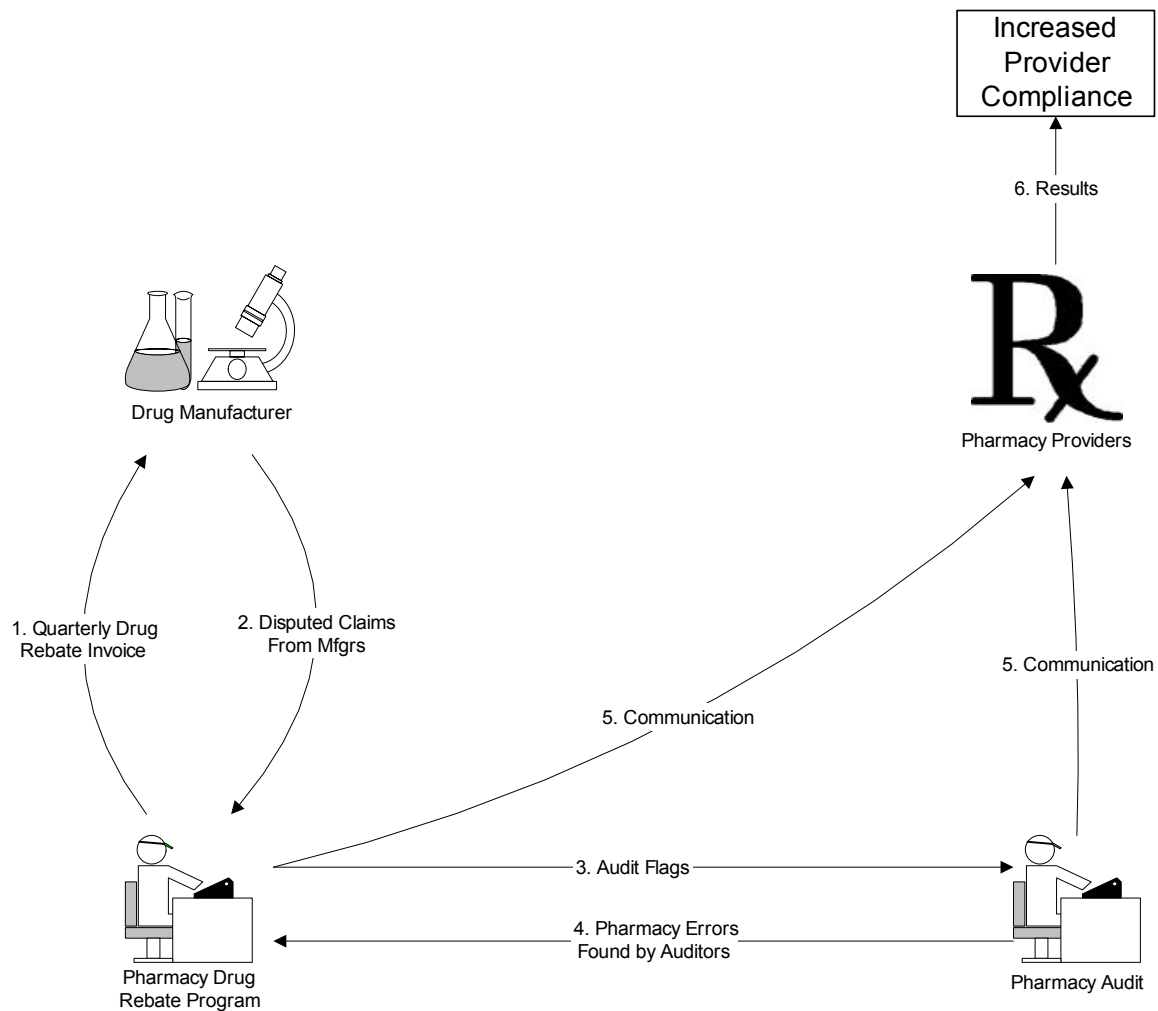
1) *Rebate Program invoices drug manufacturer for Medicaid utilization.*
2) *Drug Manufacturer's utilize their resources and expertise to reasonably dispute items they believe were billed to them (and therefore the state) in error*
3) *Dispute data along with standard federal reason codes sent to the state by the manufacturer are shared with the audit group. This aids the audit group in identifying areas ripe for billing errors/fraud.*
4) *The claims found to be submitted erroneously during the audit process are recouped from the providers and will then be imported into the LAPRIMS system for claim level tracking and audit history purposes. This data will also be used by rebate auditors during dispute resolution and it will increase the integrity of the data and processes in our rebate system and all production reports. This in turn will aid the State in collecting dollars incorrectly disputed by labelers.*
5) *Both Departments will communicate with pharmacy providers via telephone, written correspondence, remittance advice messages, and audit findings reports.*
6) *The result of this process will be increased provider compliance, which corresponds with our goal.*

B. Use of Innovative Technology

The innovation for this proposal is the technical modification to the business process. The data warehouse and analysis services are the tool we will use to implement the innovation. The basis of a data warehouse is to give the user the ability to run extremely intensive and detailed queries quickly and easily. The designers, based on intense analysis of the business processes, construct data cubes. Data cubes allow for information to be organized into different, meaningful levels of detail rather than arbitrary summarizations. This allows the data to be broken down into measures and dimensions. Measures are areas of importance to the business process such as total payments and average claim count. Dimensions are the parameters that have relevance to the particular business measure such as payment date and provider number. Users will have the ability to extract the data they require based on the dimensions set up for each cube. The proposed system will allow for the creation of the necessary cubes and will also have the ability to expand to accommodate future needs. The innovation of this technology lies in its ability to efficiently and effectively analyze data on a global scale.

C. Multi-agency Application or Portability to Other Agencies

Medicaid is the largest single payor of pharmacy claims in the State of Louisiana covering over 900,000 recipients totaling over 13 million prescriptions per year.

It is possible that this function could be performed for other processors of pharmacy claims including but not limited to Louisiana State Employees Group Benefits program. State Employees Group Benefits currently contracts with a third party to process and review pharmacy claims.

D. Benchmarking Partners and/or Best Practice References

In 1995, Louisiana began enhancing its in-state pharmacy audit program by developing new types of audits to target specific areas. Full scope audits were designed to review multiple areas including: claims verification, charges, insulin and supplies, package size, National Drug Code, generic products, third party analysis, actual acquisition costs, and invoices. Limited scope audits were created to review two areas of concern. This eliminated the necessity of reviewing and paying for full scope audits of providers who were previously deficient in only one or two areas. Other audit types were developed as pilot projects - medication compliance verification audits and desk audits. The claim level data for all audit types was obtained on paper from the fiscal intermediary. Some of the large volume providers' profiles were 400-450 pages of data. These claims were manually reviewed for potential discrepancies.

Desk audits provided a cost effective method to identify multiple discrepancies of a single provider when claims were consistently billed incorrectly. To speed up the identification process and enhance efficiency, a special request for electronic copies of a provider's past billings were requested from the fiscal intermediary. This allowed the auditors to search for the total number of discrepancies for a specific drug entity. Meanwhile, in 2000, the Bureau enhanced our rebate program by accessing claims through a relational database system via a contract with the University of New Orleans.

To adequately assess claims data with less time and money expended, the Bureau is proposing to develop a technology based risk assessment methodology to identify billed pharmacy claims that are possibly out of compliance with Medicaid rules. The claims data will be run against a set of parameters (risk factors) to determine possible compliance.

We will perform a global review on currently processed claims. This allows all claims billed by any provider to be considered for audit and adds a timeliness factor for recoveries and corrective action to take place. The most cost effective method to adequately assess claims data is systematic

review designed to find outliers. The use of the data warehouse will help ensure the integrity of current billings in the pharmacy program.

E. Long-range Planning

Since the seventies, Medicaid has reviewed pharmacy billings and required pharmacists to provide documentation for billing justification. Audits were performed on-site by contracted field auditors. In 1995, the Bureau created a desk audit to capture more data with less dollars expended. The data was captured on paper profiles for manual review. Advanced technology has created the ability to capture and sort more data, and identify outliers from billings at a lower cost than field audits. The Bureau has decided to proceed in this direction to allow audits to be claim based, not provider based, eliminating the need to target providers while enhancing the efficiency of the audit process.

F. Performance Goal

Assuming July 1, 2004 start date for operations:

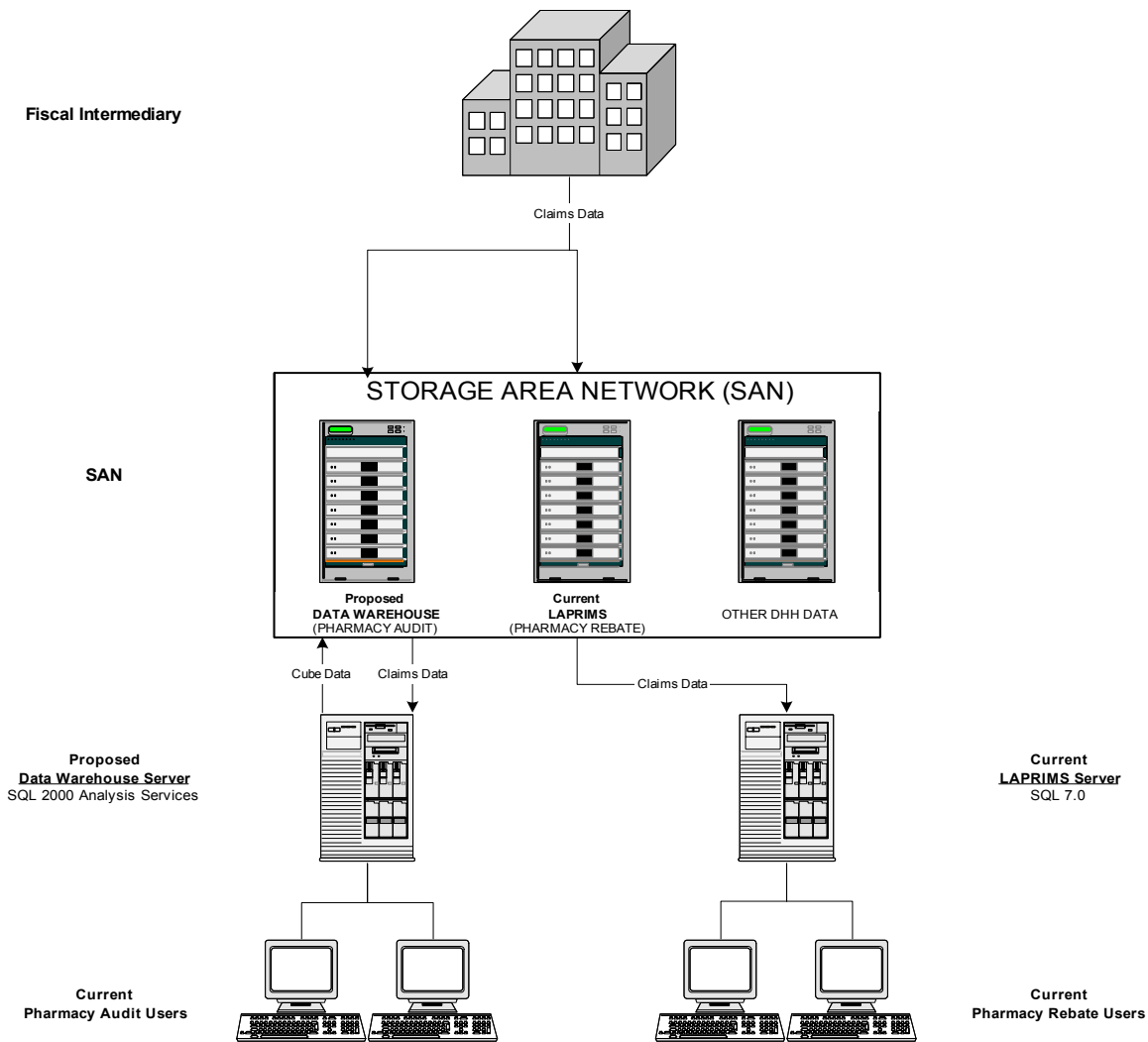| Indicator Name	Indicator Value FY 2005	Indicator Value FY 2006	Indicator Value FY 2007
Number of desk audits	100	200	200
Number of pharmacies field audited	24	48	72
Dollars Recovered	$1,000,000	$1,500,000	$2,000,000

The pharmacy rebate group has already developed a measurement plan for productivity which is reported on monthly and has been audited by legislative performance auditors. Not only will dollars be identified for recovery, but the cash collected due to auditor efforts will be recorded. Reports on the number and each type of audit will be presented annually, along with the types and volume of discrepancies found and actions taken to insure further compliance. In addition to the above indicators, we will also regularly report our findings as shown below:

Hardcopy Report Number of claims paid during audit period
                No. of claims reviewed
                No. of discrepancies identified
                No. of MAC overrides billed
                No. of Pro-DUR overrides billed
                No. of Prescription Limit Overrides billed
                No. of controlled substances billed

G. Technical Approach

The core technology will be Microsoft SQL Server 2000 Analysis Services and a data warehouse. Medicaid Pharmacy claims data will be imported monthly from the fiscal intermediary (currently 140 million records total with approximately 1 million new records each month). Data cubes will be created for very fast querying by auditors throughout the rest of the month. Data warehousing technology is more appropriate than a traditional relational database because of the vast size of the raw data and the nature of the queries that will be used to support the audit function.

Fiscal Intermediary

Claims Data

STORAGE AREA NETWORK (SAN)

SAN

Proposed
DATA WAREHOUSE
(PHARMACY AUDIT)

Current
LAPRIMS
(PHARMACY REBATE)

OTHER DHH DATA

Cube Data   Claims Data   Claims Data

Proposed
Data Warehouse Server
SQL 2000 Analysis Services

Current
LAPRIMS Server
SQL 7.0

Current
Pharmacy Audit Users

Current
Pharmacy Rebate Users

1) Technical Description

The implementation of a data warehouse will require an upgrade to our current Storage Area Network (SAN). A fiscal intermediary currently supplies claim data on a monthly basis. This data load will be enhanced to include additional information necessary to accomplish the audit function. The data received from the fiscal intermediary will be stored in two different sections of the SAN. One is currently for the pharmacy rebate database (LAPRIMS) and the other will be for the pharmacy auditors (data warehouse). The new section of the SAN will be used to store only the information for the data warehouse. It will also require a new server dedicated solely for this project. Our current server houses a relational database for performing all current rebate functions. The new server will be used for the data warehouse and while the data will be similar, the organization and sorting or indexing will be completely different. The current database is used for transaction processing and is highly normalized, which allows it to run efficiently. The data warehouse will be designed with primarily analysis purposes in mind. It will be highly de-normalized which will allow for efficient and effective queries. Data cubes, which form the structure of the warehouse, will be built and maintained by the new server. Accomplishing the needs of the pharmacy audit department would be nearly impossible with a relational database such as the current system.

To answer queries in a reasonable time frame using traditional relational database management systems (RDMS) requires indexes, which are very large and costly (in resources) to maintain. Due

to the large amounts of claim data and different ways of querying that data to audit pharmacies efficiently we would need large numbers of indexes on a relational database. This would negatively affect the performance of the system by causing extremely time-intensive queries. The data warehouse will bring back these same queries in a matter of seconds.

2) Interoperability
The hardware required for this project is an upgrade to the current system in place to handle Pharmacy Rebate and other BHSF services. Apart from accomplishing the needs of Pharmacy Audit, the data warehouse will also be an extremely useful tool for the rebate auditors. Since the information they use is from the same data pool, they will also have the ability to run quick and detailed queries and make better use of their time.

3) Scalability
The plan is to upgrade the SAN from the CS400 to the CS600. The CS600 allows up to 17.5 terabytes (TB) of storage. There will initially be 1 TB allocated for this project and there will be plenty of room for growth. Servers will be installed within the existing BHSF network in the racks located in the current server room.

The data warehouse can also benefit the existing rebate system. Currently, claim level data is provided to labelers through the rebate staff upon request, requiring their time and effort. These requests for large amounts of claim data put a strain on existing system resources and in turn affect the daily productivity of the rebate staff. The new data warehouse would enable us to create an innovative method for labelers to securely log in to a web page and access their claim level data independent of an auditor's assistance and without the strain on the current RDBMS system. The immediate access by labelers to State claim data will aid the State in a more efficient and quicker collection of rebate dollars.

4) Maintaining the System
The physical components of the new system will be maintained in the same manner as the current system. UNO Tech Support Department handles the regular upkeep of all technical equipment and they will also be responsible for installing the hardware needed for the project. UNO Software development will be responsible maintaining the information contained in the system.

H. Implementation Approach

This program will be implemented in phases.

Phase	Timeline	Purpose	Description
1	11/1/03-1/31/04	Development Planning/Desk Audit Testing	Test perform several full scope desk audits utilizing existing pharmacy rebate staff and equipment. This will be necessary to document the knowledge base and outline procedures that will be necessary to give development staff the needed background to aid in data warehouse and analysis services development
2	12/1/03-12/31/03	Issue RFP and select contractor	Professional services will be required to design, program, and implement the proposed data warehouse and to add audit modules to existing LAPRIMS systems in order to integrate functionality.
3	2/1/04-6/30/05	Development Services Contract	Analysis, server installation, design and creation of Data warehouse.
4	7/1/04	Begin Normal Operations	Standard Queries will be run each month as new claims are loaded into the warehouse. Four (4) auditors and one (1) audit supervisor will staff the pharmacy audit function through FY 2005.

I. Assessment of Risks

<u>Obsolescence</u> – the data involved with this project will always need to be stored and organized. The data warehouse will not become obsolete because we will continue to add claims monthly, and upgrade operating systems as needed. The data warehouse provides us with the best means to do this now as well as the ability to expand for future needs.

<u>External influences</u>-Pharmacies will always make some errors, and will need to be made aware of misbillings.

<u>Staffing</u> – turnover can be an issue, however, we have had no turnover in the pharmacy rebate group for two years which would indicate a healthy work environment. We believe turnover would be less significant under this proposed method than with outsourcing.

<u>Scheduling</u> – the staff that will be working on this project has exhibited proficiency working with a contractor to develop and implement a similar system, LAPRIMS. We remained on schedule and successfully have implemented and have been innovatively using that program to generate and collect revenue for the state[6].

J. Integration with Existing Technologies

This project will build upon a current system that is in place. The current SAN is going to be upgraded to handle the new project. The data cubes created for the data warehouse will be approximately 50 GB in size, which is the reason for needed space. The creation of the data cubes along with the querying of the information is a highly RAM intensive process. A separate server needs to be used in order to handle the processing needs of the data warehouse. The plan is to have the two systems remain as closely linked as possible so that communication between Pharmacy Audit and Pharmacy Rebate will be strong.

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[6] http://www.lla.state.la.us/perform/dhhpp03.pdf, Department of Health and Hospitals, Medical Vendor Program-Pharmacy Program - Incentive Rewards (03501007) (25 pgs)

K. Project Budget and Costs

1. *Equipment.*

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EQUIPMENT

Personal Computer. One (1) personal computer will be needed for each auditor and data entry tech (7 computers). Cost is $1800 each.

Laptop Computer. One (1) laptop computer will be needed for each of the four staff auditors. Cost $2500 each.

Portable Printers. One (1)) portable printers/scanners will be needed for each of the four field auditor at a cost of $400 each.

Network Printer. One (1) Network printer for use by all staff. Cost $4000

Network Server. An Enterprise quality high performance server with 3 Gigabytes of RAM will be located at the State Office Building. The server will have 4 processors and will run the SQL Server 2000 software. Cost $40,000

SAN Upgrade. The existing Storage Area Network (SAN) will be upgraded to provide initially, one (1) Terabyte of disk space, with more available as needed. This will house the data warehouse.   Cost: $148,800

Cost Summary:

Item	Quantity	Unit Price	Total
Personal Computers	7	$ 1,800	$12,600
Laptop Computers	4	$ 2,500	$10,000
Portable Printers	4	$ 400	$ 1,600
Network Printer	1	$ 4,000	$ 4,000
Network Server	1	$40,000	$40,000
SAN Upgrade	1	$148,800	$148,800
Total			**$217,000**

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2. *Software.*

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SOFTWARE

SQL Server 2000 Enterprise Edition. Includes fees for 4 processor licenses, and 25 Microsoft SQL Server 2000 Client Access Licenses. Total Cost $51,800

Additional Usoft Licenses. 1 usoft license is needed for each user of LAPRIMS. Seven (7) additional licenses will be needed at $1000 per unit. Total Cost $7000 annually.

Crystal Reports Software. 7 additional licenses will be needed at $400 per user. Crystal reports is our standard reporting tool. Total Cost $2800

Physician Desk Reference Online. Web access for five (5) users to the most up to date drug entities and their descriptions. Total Cost $1500 annually.

Drug Imprint Software – Software that provides color pictures of drugs for use in recipient prescription verification audits. Total Cost $3600 annually.

Cost Summary:

Item	Quantity	Unit Price	Total
SQL Server 2000 Enterprise Edition	1	$51,800	$51,800
Additional Usoft Licenses	7	$ 1,000	$ 7,000
Crystal Reports Software	7	$ 400	$ 2,800
Physician Desk Reference Online	1	$ 1,500	$ 1,500
Drug Imprint Software	1	$ 3,600	$ 3,600
Total			**$65,700**

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3. Telecommunications.

TELECOMMUNCIATIONS
None requested

4. Professional/Contracted Services

PROFESSIONAL SERVICES

Systems Development Contract. Professional services will be required to design, program, and implement the proposed data warehouse and to add audit modules to existing LAPRIMS systems in order to integrate functionality. It is estimated that 2350 hours of consulting services at $212/hr will be required.

Cost Summary:

Item	Quantity	Unit Price	Total
Professional Services	2350	$212/hr .	$498,200
Total			**$498,200**

5. Other.

OTHER COSTS *(EXAMPLE)*

Audit Staff. The existing University of New Orleans contract will provide 1 audit supervisor, 4 audit staff, 1 software developer, 2 TPL recovery staff and 4 student workers to staff this endeavor. (Costs listed below are annual)

Cost Summary:

Item	Quantity	Unit Price	Total	
4 staff auditors, salary plus benefits	4	$45,000		$180,000
1 audit supervisor	1	$54,450	$ 54,450	
2 TPL Recovery staff	2	$45,000		$ 90,000
1 software developer	1	$50,000		$ 50,000
4 student workers (data entry)	4	$ 7,000	$ 28,000	
Travel/Supplies/operational services for above employees, annually	11	$6,757	$ 74,331	
Total			**$246,000**	

V FUNDING REQUESTED

Identify the total amount to be funded by the Louisiana Technology Innovation Fund. Identify and explain other sources, including agency matching funds, federal funds, or other funding, if available. Break down requested funding by category as defined above.

FUNDING REQUESTED

Other Sources: Federal Funding will be obtained for 50% of the costs associated with this endeavor.

Funding Category	Total Cost	Other Sources	Funding Requested
Equipment	$217,000	$108,500	$108,500
Software	$63,902	$ 31,951	$ 31,951
Telecommunications	$ 0	$ 0	$ 0
Professional Services	$498,200	$249,100	$249,100
Other	$238,390	$119,195	$119,195
Total	**$1,017,492**	**$508,746**	**$508,746**

VI COST/BENEFIT ANALYSIS

Provide a cost/benefit analysis including a fiscal note clarifying all on-going or recurring operational costs for three (3) years outlining costs and cost savings (see sample format in Attachment I as a guide).

		Expenditure Increase (Decrease)			
STATE COSTS	2003-4		2004-5		2005-6
Personal Services	$ -	$	-	$	-
Operating Services	$ -	$	-	$	-
Professional Services	$ 498,200.00	$	106,000.00	$	106,000.00
Other Charges	$ 238,390.00	$	476,780.00	$	492,878.00
Equipment	$ 280,902.00	$	12,102.00	$	12,102.00
Total	$ 1,017,492.00	$	594,882.00	$	610,980.00

There is no state personnel requested

Narrative Explanation of Expenditure Impact

1) **Implementation Costs**

    No increased state personnel is required to support this project.

    The total expenditure increase for FY 2003-4 is $1,017,492 of which we are requesting 50% or $508,746 from the Technology Innovation Fund. The implementation costs are made up of primarily equipment and development/operations contracts as outlined in the tables within the proposal. Professional services are highest in the initial year due to system development. The subsequent years are for 500 support hours for both the rebate and audit function, since they will both be using the same program.

    Other charges include the University of New Orleans contract whose staff currently resides in-house and executes the pharmacy rebate program. These charges would be for additional staff to man the proposed audit function. It assumes UNO staff is at ½ cost for FY 2003-4.

    Equipment is primarily a one time cost as outlined in the tables within the proposal. The FY 05 and 06 costs are for software maintenance only.

    The state plans to offset the state portion of FY 05 and 06 costs with the recovery dollars collected from providers based on audit/review findings and third party liability recoveries. We anticipate audit recoveries to be $1million in FY 05 to 2 million in fiscal year 2007.

2) **Source of Funds (Include any alternative sources that may be available)**

    50% of the project would be funded by Federal matching dollars in each fiscal year.

MEANS OF FINANCING FOR ABOVE EXPENDITURES		
	STATE GEN. FUND	FEDERAL FUNDS
FISCAL YEAR		
2003-4	$ 508,746.00	$ 508,746.00
2004-5	$ 297,441.00	$ 297,441.00
2005-6	$ 305,490.00	$ 305,490.00

Narrative Explanation of Revenue Impact

State __all__ assumptions and show __all__ calculations. If there is no fiscal impact, clearly and completely explain why.

50% of the project would be funded by Federal matching dollars in each fiscal year.

In 1999, the DHH issued a Request for Proposal for a contractor to perform Medicaid Pharmacy Compliance Audits. The estimated cost of these audits performed today is $1.6 million per year for fiscals 2004 through 2006. The proposed in-house method requires a capital outlay of $1million in fiscal year 2004 and is reduced substantially in fiscal years 2005 and 2006.

The cost of technology associated with this contract will have to be borne by the Bureau either through our own in-house system development or a capital outlay to an out-sourced contractor. It is estimated that this process will result in pharmacy recoupments ranging from $1 million in fiscal year 2005 to 2 million in fiscal year 2007.

In regard to the Third Party Liability (TPL) recovery process, the Department plans to develop, as a result of the implementation of the NCPDP 5.1 standard, a cost-avoidance program for pharmacy claims in FY 2004. At this time, we are unable to determine the dollar value which will be cost avoided. However, based on third party recoveries currently reported, it is estimated to be several million dollars annually.

The current TPL contract with Public Consulting Group (PCG) will terminate on April 30, 2004. The department will assume the function of the PCG contract for TPL recovery of pharmacy claims through this TIF funding and UNO staff. Therefore, any paid pharmacy claims to which TPL applies which have not been cost avoided under NCPDP 5.1 standard, will be pursued under this proposed process.

VII   SIGNED STANDARD FORM

All standard proposal forms must be submitted along with a cover letter signed by the Secretary, Undersecretary (or their equivalents) and the Project Manager.

ATTACHMENTS (Optional, limit to 2 pages)

The Louisiana Medicaid Pharmacy Benefits Management (LMPBM) Section is responsible for the development, implementation and administration of the Medicaid pharmacy program within the Bureau of Health Services Financing (BHSF). The LMPBM is the first state-owned and administered Pharmacy Benefit Management (PBM) System in the nation. The LMPBM Section is charged with the responsibility of assuring quality pharmacy services while developing efficiencies in operation, service and cost. The LMPBM currently achieves over $187 million annually in cost containment through the various initiatives that have been implemented in the LMPBM System. (An additional $61million in cost containment annually is projected with the Prior Authorization and State Supplemental Rebate processes implemented in June, 2002.)   The LMPBM Section is responsible for the daily operational activities of pharmacy prescription services, one of the largest service areas under the Medicaid program with annual expenditures in excess of $752 million for payment of approximately 13.8 million prescription claims. In addition, the LMPBM, through its federally mandated rebate system and provider fees, generates the largest amount of revenues (Nearly $158 million has been generated annually from over 400 drug manufacturers through the federal rebate system and another $61 million is projected to be generated through the new prior authorization and state supplemental rebate system.) within the Bureau. The pharmacy program covers all Food and Drug Administration (FDA) approved legend drugs that meet the OBRA '90 and OBRA '93 criteria with a few exceptions. The drug file contains over 120,000 drug products (brand, generic and some over-the counter) of which over 41,000 are payable. The LMPBM Section determines the reimbursement methodology for both the drug ingredient cost and the dispensing fee for covered drugs.

- The LMPBM Section consists of the following components which the project leader directs: policy, program development and implementation, network development, program coverage and preferred drug list (PDL) development and implementation, prior authorization for certain drug categories, federal upper limits and state maximum allowable costs incentives for multiple source drugs, claims management, clinical interventions, pre- and post-payment drug utilization review, federal and state supplemental pharmaceutical manufacturer rebates, potentially 400 individual contracts with manufacturers in the state supplemental rebate program, pharmacy provider desk and field audits, disease management, outcomes management, recipient lock-in program, provider help desk, clinical intervention desk, provider relations and provider education to pharmacists and prescribers (physicians, dentists, optometrists, podiatrists, nurse practitioners and other practitioners authorized to prescribe drugs) on peer-based prescribing and dispensing practices.

Staff in this Section provides regulatory supervision regarding the discharge of their contractual requirements to six (6) contractors including the fiscal intermediary for activities related to the pharmacy program.   These six contracts include the following functions essential to the administration of the LMPBM program:

1.	Fiscal Intermediary Contract - performs pharmacy-related services which include:
- Pharmacy claim processing though an on-line real-time process Point of Sale (POS) system of approximately 13.5 million prescriptions per year.
- Retrospective Drug Utilization Review (LADUR)
- Prospective Drug Utilization Review (UniDUR)
- Disease State Management Initiatives (DSM)
- Educational brochures - Disease state specific-(Prescriber & Pharmacy)
- Educational brochures - Disease State specific-(Recipient)
- Educational Articles - "Provider Update" newsletter
- Lock-In Program (1,800 recipients)
- Drug Utilization Review Board (DURB) coordination
- Surveillance Utilization Review (SUR) post payment services monitoring
- Louisiana Pharmacy Federal and State Supplemental Rebate Information Management System (LAPRIMS)
- Prescriber and Pharmacist Peer-based profiling
- Preferred Drug List and Prior Authorization System

2.   Provider Synergies Contract - provides technical support for the PDL development and maintenance, State Supplemental Rebate manufacturer contract negotiations, and other support functions associated with the State Supplemental Rebate System and PDL.
3.   Pharmacy Audit Contract - performs retrospective review of pharmacy claims for approximately 375 pharmacy providers annually to determine compliance with LMPBM program requirements.
4.   Rebate Contracts - University of New Orleans and the fiscal intermediary - provide network administration for the federally mandated and optional state supplemental Drug Rebate Program and accounting/audit support for Drug Rebate Program functions which include reconciliation of over 40,000 drug records invoiced to over 400 drug manufacturers quarterly ($124 million annually in federally mandated rebate program and a projected $62 million annually in the newly implemented optional state supplemental rebate program).
5.   University of Louisiana-Monroe, College of Pharmacy - participates as a representative on the Pharmaceutical and Therapeutics Committee and as a consultant resource in the Preferred Drug List (PDL) development, administers prior authorization operation, and performs clinical education functions (i.e. Drug Utilization Review, Disease Management, Outcomes Management and pharmacoeconomic and outcomes research).
6.   Reimbursement Survey Contract - performs surveys of pharmacy providers in areas of drug ingredient costs and dispensing fees for use in determining reimbursement rates

The LMPBM Section initiates policy development, implements new policies and clarifies existing pharmacy policies, which include the services associated with outpatient drugs and all Medicare/Medicaid crossover services. The Section approves all new drugs added to program coverage and establishes any limitations on reimbursement or coverage in accordance with the federally approved reimbursement methodology. The Section directs an extensive network of over 1200 pharmacy providers. This Section is also responsible for the integrity of several sub-systems including the drug file of over 120,000 drugs, the Drug Utilization Review subsystem and the drug portion of the Surveillance and Utilization Review subsystem.

LMPBM Section staff communicate extensively with federal officials, federal and state legislators, health care experts, consumers of pharmacy services, professional experts (statisticians, health care accountants and attorneys, third party administrators, etc.) and clinicians. Close coordination with the Policy Development and Implementation Section, the Program Operations Section, Financial Operations Section, Program Integrity Section and the Medicaid Management Information System (MMIS) Section of the BHSF is required on a regular basis. Program oversight is provided by the federal Centers for Medicare and Medicaid Services (CMS), the federal Office of Inspector General and the state Attorney General's office.

In June, 2002, as authorized by Act 395 of the 2001 Regular Session of the Legislature, the Department implemented a prior authorization process with a preferred drug list (PDL) for certain designated drugs in selected therapeutic classes covered under the LMPBM Program and a State Supplemental Rebate Program. In addition, as mandated by Act 395, the Department implemented and administers a prescriber and pharmacist peer-based profiling program. Implementation and administration of these processes were delegated to the LMPBM Section of BHSF and requires additional staff and manpower as well as additional contracted services for operation of these new program features.

In March 2003 the Department implemented a monthly prescription limit in the program. Administration of this program policy will also be delegated to the LMPBM Section. Additional positions are being assigned to perform tasks associated with the operation of this program feature, i.e. policy development and implementation, monitoring, reporting and communication with providers, recipients, legislators, etc. A toll free line has been installed to facilitate the Section's timely response to inquiries associated with the prescription limit.